FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026195

Facility Name: LIEBERMAN LONG TERM CARE FACILITY

Address: 9700 Gross Point Rd. (Number) Skokie (City) 60076 (Zip Code)

County: Cook

Telephone Number: 847-674-7210 **Fax #** 847-674-6366

IDPA ID Number: 36-2727597-001

Date of Initial License for Current Owners: 9/18/81

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (C) (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: STEVEN N. LAVENDA **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barbara Wexler

(Title) Adminastrator

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) Steven N. Lavenda, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	240	Skilled (SNF)	240	87,840	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	240	TOTALS	240	87,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,184	12,303	2,638	27,125	8
9	SNF/PED					9
10	ICF	35,268	24,084		59,352	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,452	36,387	2,638	86,477	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.45%

D. How many bed-hold days during this year were paid by Public Aid? 516 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Day Care and Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/20/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/20/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 2,606

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILI # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	620,828	89,990	64,168	774,986		774,986		774,986			1
2	Food Purchase		636,604		636,604		636,604	(79,402)	557,202			2
3	Housekeeping	286,518	36,015	93,049	415,582		415,582		415,582			3
4	Laundry	131,817	13,485	165,654	310,956		310,956		310,956			4
5	Heat and Other Utilities			232,871	232,871		232,871		232,871			5
6	Maintenance	276,110	32,014	244,468	552,592		552,592	(44,899)	507,693			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,315,273	808,108	800,210	2,923,591		2,923,591	(124,301)	2,799,290			8
	B. Health Care and Programs											
9	Medical Director			9,167	9,167		9,167		9,167			9
10	Nursing and Medical Records	4,678,628	301,868	135,456	5,115,952		5,115,952		5,115,952			10
10a	Therapy	143,534		560	144,094		144,094		144,094			10a
11	Activities	235,399	22,738	2,589	260,726		260,726		260,726			11
12	Social Services	203,417	273	28,699	232,389		232,389		232,389			12
13	Nurse Aide Training											13
14	Program Transportation			1,555	1,555		1,555		1,555			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,260,978	324,879	178,026	5,763,883		5,763,883		5,763,883			16
	C. General Administration											
17	Administrative	422,060			422,060		422,060		422,060			17
18	Directors Fees											18
19	Professional Services			335,795	335,795		335,795	(6,015)	329,780			19
20	Dues, Fees, Subscriptions & Promotions			75,486	75,486		75,486	183	75,669			20
21	Clerical & General Office Expenses	529,306	41,482	68,586	639,374		639,374	96,930	736,304			21
22	Employee Benefits & Payroll Taxes			1,646,481	1,646,481		1,646,481	(5,194)	1,641,287			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,632	8,632		8,632		8,632			24
25	Other Admin. Staff Transportation			1,974	1,974		1,974	2,844	4,818			25
26	Insurance-Prop.Liab.Malpractice			71,177	71,177		71,177	4,990	76,167			26
27	Other (specify):*											27
28	**TOTAL General Administration**	951,366	41,482	2,208,131	3,200,979		3,200,979	93,738	3,294,717			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,527,617	1,174,469	3,186,367	11,888,453		11,888,453	(30,563)	11,857,890			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

LIEBERMAN LONG TERM CARE FACILITY **0026195**

COST REPORT RECLASSIFICATIONS

07/01/99

06/30/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS		
2	FOOD		

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY #0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			981,282	981,282		981,282	2,680	983,962			30
31	Amortization of Pre-Op. & Org.			15,292	15,292		15,292	(15,292)				31
32	Interest			571,084	571,084		571,084	(177,049)	394,035			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,600	25,600		25,600		25,600			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,593,258	1,593,258		1,593,258	(189,661)	1,403,597			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,666	215,632	315,298		315,298		315,298			39
40	Barber and Beauty Shops		887	39,072	39,959		39,959		39,959			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,760	131,760		131,760		131,760			42
43	Other (specify):*			565	565		565	(566)	(1)			43
44	**TOTAL Special Cost Centers**		100,553	387,029	487,582		487,582	(566)	487,016			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,527,617	1,275,022	5,166,654	13,969,293		13,969,293	(220,790)	13,748,503			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,680	30		9
10	Interest and Other Investment Income	(177,049)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,679)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,839)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(277)	20		28
29	Other-Attach Schedule	(202,434)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (382,598)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	161,808		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 161,808		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (220,790)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
LIEBERMAN LONG TERM CARE FACILITY
ID# 0026195
Report Period Beginning: 07/01/99
Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 8,702	6	1
2				2
3				3
4	Amortization Expense	(15,292)	31	4
5	Misc. Income	(21,618)	21	5
6	Ferip/Ferst Income	(37,321)	22	6
7	Catering Income o/s CJE	(10,324)	2	7
8	Catering Income	(44,154)	2	8
9	Wine & Liquor	(3,174)	2	9
10	Marketing Expense	(566)	43	10
11	Jewish Federation Chicago - Lobbyist Expense	(6,015)	19	11
12	Supplies Clearing Account	(19,071)	2	12
13				13
14	Repair & Maint. Capitalized	(43,302)	6	14
15	Repair & Maint. Capitalized	(10,299)	6	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(202,434)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(79,402)	0	0	0	0	0	0	0	0	0	0	(79,402)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(44,899)	0	0	0	0	0	0	0	0	0	0	(44,899)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(124,301)	0	0	0	0	0	0	0	0	0	0	(124,301)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,015)	0	0	0	0	0	0	0	0	0	0	(6,015)	19
20	Fees, Subscriptions & Promotions	(3,116)	0	3,299	0	0	0	0	0	0	0	0	183	20
21	Clerical & General Office Expenses	(21,618)	0	118,548	0	0	0	0	0	0	0	0	96,930	21
22	Employee Benefits & Payroll Taxes	(37,321)	0	32,127	0	0	0	0	0	0	0	0	(5,194)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	2,844	0	0	0	0	0	0	0	0	2,844	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,990	0	0	0	0	0	0	0	0	4,990	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(68,070)	0	161,808	0	0	0	0	0	0	0	0	93,738	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(192,371)	0	161,808	0	0	0	0	0	0	0	0	(30,563)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	2,680	0	0	0	0	0	0	0	0	0	0	2,680	30
31	Amortization of Pre-Op. & Org.	(15,292)	0	0	0	0	0	0	0	0	0	0	(15,292)	31
32	Interest	(177,049)	0	0	0	0	0	0	0	0	0	0	(177,049)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(189,661)	0	0	0	0	0	0	0	0	0	0	(189,661)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(566)	0	0	0	0	0	0	0	0	0	0	(566)	43
44	**TOTAL Special Cost Centers**	(566)	0	0	0	0	0	0	0	0	0	0	(566)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(382,598)	0	161,808	0	0	0	0	0	0	0	0	(220,790)	45

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None		None		Council for Jewish Eld	Chicago	Community Serv.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Fees & Subscription	$	Council for Jewish Elderly		$ 3,299	$ 3,299	15
16	V	21	Clerical/General Office		Council for Jewish Elderly		118,548	118,548	16
17	V	22	Employee Benefits		Council for Jewish Elderly		32,127	32,127	17
18	V	25	Other Admn. Transportation		Council for Jewish Elderly		2,844	2,844	18
19	V	26	Insurance		Council for Jewish Elderly		4,990	4,990	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 161,808	$ * 161,808	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACII # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1					N/A				$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Council for Jewish Elderly
Street Address: 3003 W. Touhy Ave.
City / State / Zip Code: Chicago, IL 60645
Phone Number: (847) 674-7210
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	20	Fees & Subscription	Direct Cost	9,449	9	$ 9,449	$	3,299	$ 3,299	1
2	21	Clerical/General Office	Direct Cost	611,062	9	611,062		118,548	118,548	2
3	22	Employee Benefits	Direct Cost	92,031	9	92,031		32,127	32,127	3
4	25	Other Admn. Transportation	Direct Cost	25,071	9	25,071		2,844	2,844	4
5	26	Insurance	Direct Cost	14,295	9	14,295		4,990	4,990	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 751,908	$		$ 161,808	25

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACIL # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Il Development Finance Author.		x	Mortgage Loan		05/18/95	$ 8,000,000	$ 8,000,000		0.0450	$ 301,354	1
2	First American Bank		x	Maintenance Loan		06/25/95	41,345	13,948		Varies	1,433	2
3	Capital Endowment Fund	x		Debt Service Subsidy							105,663	3
4	First American Bank		x	Masonry Loan		01/13/98	189,124			0.0850	27,118	4
5	LaSalle Bank		x	Term Loan		05/01/99	129,292			Varies	2,367	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 8,359,761	$ 8,013,948			$ 437,934	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(43,899)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (43,899)	14
15	TOTALS (line 9+line14)						$ 8,359,761	$ 8,013,948			$ 394,035	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (177,049)	1
2												2
3	Allocated from CJE	x		Mortgage Loan - CJE							2,432	3
4	Allocated from CJE	x		Term Loan - CJE							130,717	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (43,899)	21

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 162,984 B. General Construction Type: Exterior Brick Frame Concrete, Metal Number of Stories 7

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		216,480	1980	$ 809,873	1
2					2
3	TOTALS	216,480		$ 809,873	3

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1981	1981	$ 10,023,348	$ 250,585	40	$ 250,585	$	$ 4,698,456	4
5			1983	1983	32,224	805	40	805		14,089	5
6			1984	1984	7,755	194	40	194		3,201	6
7			1987	1987	19,886		40				7
8			1986	1986	29,583	1,236	40	1,236		16,690	8
	Improvement Type**										
9	Land Improvements			81	96,365					96,365	9
10	Land Improvements			83	54,161					54,161	10
11	Land Improvements			85	3,575	169	15	169		3,575	11
12	Land Improvements			87	78,564	5,238	15	5,238		65,475	12
13	Land Improvements			88	7,394						13
14	Land Improvements			89	19,724	1,117	10	1,117		12,844	14
15	Building Improvements			90	7,500	375	10	375		7,500	15
16	Capital			90	18,636						16
17	Building Improvements			91	22,617	591	10	591		22,028	17
18	Capital			91	24,989						18
19	Capital (in excess of $4,500 not subject to deferral)			92	22,722						19
20	Capital - 30 doors & chiller repair			93	15,514	1,034	15	1,034		7,239	20
21	Building - Parking Lot			92	207,995	12,796	15	12,796		91,331	21
22	Capital - Memorial			94	603	40	15	40		280	22
23	Capital - Shades, Doors			94	5,534	369	15	369		2,583	23
24	Capital - Blinds			94	6,018	858	7	858		6,018	24
25	Capital - Thermostat Project			94	41,780	2,785	15	2,785		19,495	25
26	Electrical Motor			95	1,046	70	15	70		420	26
27	Automatic Door Parts			95	1,197	80	15	80		480	27
28	Compressor Parts			95	747	50	15	50		300	28
29	Land and Building Improvements			96	3,736,269	363,297	10	363,297		1,653,079	29
30	Carpeting			96	3,686	527	7	527		2,635	30
31	Page 12A				31,903	2,956		2,956		13,376	31
32	Page 12B				370,384	37,038		37,038		130,093	32
33	Page 12C				175,881	17,794		17,794		37,693	33
34	Page 12D				2,374,408	131,920		134,600	2,680	175,934	34
35											35
36	TOTAL (lines 4 thru 35)				$ 17,442,008	$ 831,924		$ 834,604	$ 2,680	$ 7,135,340	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Mini Blinds			96	2,742	392	7	392		1,960	9
10	Mini Blinds			96	634	91	7	91		455	10
11	Storage Cabinet			96	515	74	7	74		370	11
12	Water Pipes			96	1,265	84	15	84		420	12
13	Electrical Motor			96	1,318	88	15	88		400	13
14	Electrical Circuits			96	738	49	15	49		245	14
15	Compressor/Valves			96	1,165	78	15	78		390	15
16	Fan Motors			96	779	52	15	52		260	16
17	HVAC Piping			96	824	55	15	55		275	17
18	Damper Motors			96	1,109	74	15	74		370	18
19	Valves			96	3,184	212	15	212		1,060	19
20	Door Motion-Detector			96	648	43	15	43		215	20
21	Shelves			96	700	47	15	47		235	21
22	Electric Heaters			96	821	55	15	55		275	22
23	Water Pump			96	863	58	15	58		290	23
24	5-Gal.Cisterns			96	2,107	140	15	140		700	24
25	Shelves			97	612	87	7	87		348	25
26	Fluorescent Lamps, starters			97	2,106	301	7	301		1,204	26
27	Electrical circuit & receptacle			97	837	84	10	84		336	27
28	Electrical heaters			97	930	93	10	93		372	28
29	Motor starter			97	914	91	10	91		364	29
30	Replace HVAC bearings			97	553	55	10	55		220	30
31	Chimney Cap			97	963	96	10	96		384	31
32	Replace Valves			97	3,297	329	10	329		1,316	32
33	Side Rails			97	558	56	10	56		224	33
34	Insulation			97	700	70	10	70		280	34
35	Batteries			97	1,021	102	10	102		408	35
36	TOTAL (lines 4 thru 35)				$ 31,903	$ 2,956		$ 2,956	$	$ 13,376	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Tanks			97	1,690	169	10	169		676	9
10	Window Glass			97	6,677	668	10	668		2,672	10
11	Storage Cabinets & Hardware			97	803	80	10	80		320	11
12	Parking Lot Repaving			97	27,150	2,715	10	2,715		9,503	12
13	Engineering Study			97	18,127	1,813	10	1,813		6,345	13
14	Electrical Improvements			97	3,676	368	10	368		1,287	14
15	Reinforce Windows			97	4,500	450	10	450		1,575	15
16	Roof Replacement			97	45,050	4,505	10	4,505		15,768	16
17	Roofing Inspection			97	3,100	310	10	310		1,085	17
18	Engineering Study			97	3,165	317	10	317		1,108	18
19	Roof Replacement			97	75,825	7,583	10	7,583		26,539	19
20	Engineering Study			97	7,210	721	10	721		2,523	20
21	Carpeting			97	889	89	10	89		311	21
22	Roof Replacement			97	12,383	1,238	10	1,238		4,334	22
23	Roof Inspection			97	10,938	1,094	10	1,094		3,829	23
24	Engineering Study			97	6,844	684	10	684		2,395	24
25	Roof Replacement			97	44,901	4,490	10	4,490		15,715	25
26	Roof Inspection			97	3,563	356	10	356		1,247	26
27	Engineering Study			97	4,772	477	10	477		1,670	27
28	Electrical Systems			97	1,171	117	10	117		410	28
29	Roof Inspection			97	5,753	575	10	575		2,013	29
30	Engineering Study			97	2,067	207	10	207		724	30
31	Roofing Inspection			97	37,440	3,744	10	3,744		13,104	31
32	Engineering Study			97	8,470	847	10	847		2,964	32
33	Masonry Repair			97	7,073	707	10	707		2,475	33
34	Roof Inspection			97	2,575	257	10	257		901	34
35	Roofing Inspection			97	24,572	2,457	10	2,457		8,600	35
36	TOTAL (lines 4 thru 35)				$ 370,384	$ 37,038		$ 37,038	$	$ 130,093	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Kitchen Oven, Freezer, Shelves			97	4,806	481	10	481		1,682	9
10	CJE Friends, Flooring, Signs			97	9,189	919	10	919		3,216	10
11	Alarm System			98	706	70	10	70		140	11
12	Electrical Work			98	2,827	282	10	282		564	12
13	Electrical Work			98	2,400	240	10	240		480	13
14	Kohler Pedestal & Plumbing			98	7,122	712	10	712		1,424	14
15	AC Repair Parts			98	2,214	220	10	220		440	15
16	Parts & Services			98	7,480	748	10	748		1,496	16
17	Boiler Repair			98	10,543	1,054	10	1,054		2,108	17
18	Boiler Supplies			98	2,800	280	10	280		560	18
19	Draw Eq.			98	2,000	200	10	200		400	19
20	AC Repair Parts			98	239	23	10	23		47	20
21	Building/Maint.Supplies			98							21
22	Building/Maint.Supplies			98							22
23	Building/Maint.Supplies			98							23
24	Building/Maint.Supplies			98							24
25	Building/Maint.Supplies			98	1,191	119	10	119		239	25
26	Digital Scale			98	382	38	10	38		76	26
27	Air Conditioner			98	101,153	10,112	10	10,112		20,228	27
28	Replace Blinds 13 rooms			98	1,645	235	7	235		471	28
29	Replace Blinds 13 rooms			98	1,645	235	7	235		471	29
30	Carpet			98	1,699	242	7	242		484	30
31	Install new Lochinvar Sys.			98	6,300	630	10	630		1,260	31
32	Motion Detector, Installation			98	2,980	298	10	298		596	32
33	Bearing Ass. Impeller, Seals			98	2,369	237	10	237		474	33
34	Temp. Eng. Help			98	1,512	151	10	151		301	34
35	Maintenance			98	2,679	268	10	268		536	35
36	TOTAL (lines 4 thru 35)				$ 175,881	$ 17,794		$ 17,794	$	$ 37,693	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Reconfigure Timer Contl.			98	2,573	257	10	257		514	9
10	Door Restraints/Installation			98	4,700	470	10	470		940	10
11	Mechanical Insulation			98	1,835	184	10	184		368	11
12	Asphalt Rep./Seal/Stripe/Crackfill			98	7,531	753	10	753		1,506	12
13	Various Eq., Cleaning, Testing			98	5,960	596	10	596		1,192	13
14	Glass & Insulating Units			98	2,548	255	10	255		498	14
15	CCTV Security System			98	5,980	598	10	598		897	15
16	Concrete Work			98	4,475	448	10	448		672	16
17	CCTV Security System			99	10,080	1,008	10	1,008		1,512	17
18	Windows Replacements			99	458,343	34,450	10	34,450		62,452	18
19	Land Improvements			99	7,610	487	15	487		741	19
20											20
21	Roofing			97	28,268	2,827	10	2,827		9,894	21
22	Paving			96	5,000	500	10	500		1,750	22
23											23
24	Gas Heaters			97	955	96	10	96		288	24
25	Roof Flashing			96	670	67	10	67		268	25
26	Wallpaper			97	277	28	10	28		81	26
27	Wallpaper			97	1,120	112	10	112		336	27
28	Wallpaper			97	32	3	10	3		10	28
29	Magnetic Door			97	2,766	277	10	277		831	29
30											30
31	Page 12E				253,168	12,658		12,658		12,658	31
32	Page 12F				1,516,916	75,846		75,846		75,846	32
33	Page 12G				53,601			2,680	2,680	2,680	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,374,408	$ 131,920		$ 134,600	$ 2,680	$ 175,934	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpet			00	512	26	10	26		26	9
10	Awning			00	5,474	274	10	274		274	10
11	Replace Door			00	1,580	79	10	79		79	11
12	Design Consultation			00	683	34	10	34		34	12
13	Design Consultation			00	2,405	120	10	120		120	13
14	Compactor Mower			00	792	40	10	40		40	14
15	Steamer & light			00	2,157	108	10	108		108	15
16	Med Room Keypads			00	3,009	150	10	150		150	16
17	Design Services			00	443	22	10	22		22	17
18	Design Consultation			00	1,439	72	10	72		72	18
19	Architect Review of Lieberman			00	5,899	295	10	295		295	19
20	Design Services			00	420	21	10	21		21	20
21	Flooring Deposit			00	24,000	1,200	10	1,200		1,200	21
22	Wallcovering			00	1,021	51	10	51		51	22
23	Doors			00	4,900	245	10	245		245	23
24	Light fixtures			00	66,360	3,318	10	3,318		3,318	24
25	Compactor			00	10,000	500	10	500		500	25
26	Kitchen re-wire			00	1,013	51	10	51		51	26
27	Replace air conditioner			00	104,900	5,245	10	5,245		5,245	27
28	Water Heater			00	3,225	161	10	161		161	28
29	Exhaust Fan			00	985	49	10	49		49	29
30	Re-pipe kitchen			00	4,850	243	10	243		243	30
31	Front Handicap Door			00	1,300	65	10	65		65	31
32	Lighting			00	1,425	71	10	71		71	32
33	Lighting			00	1,450	73	10	73		73	33
34	Fan Wheels & Shaft			00	1,187	59	10	59		59	34
35	Doors			00	1,739	87	10	87		87	35
36	TOTAL (lines 4 thru 35)				$ 253,168	$ 12,658		$ 12,658	$ 0	$ 12,658	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Med Room Keypads			00	2,307	115	10	115	0	115	9
10	Sump Pump			00	631	32	10	32	0	32	10
11	Design Services			00	1,405	70	10	70	0	70	11
12	Shipping Wallpaper			00	65	3	10	3	0	3	12
13	Fencing			00	4,592	230	10	230	0	230	13
14	Handrail labor & materials			00	8,650	433	10	433	0	433	14
15						0	10	0	0	0	15
16	Tuckpointing/Masonry Repairs (see schedule attached)			00	1,499,266	74,963	10	74,963	0	74,963	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,516,916	$ 75,846		$ 75,846	$ 0	$ 75,846	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Capitalized Deferred Maint. Cost 00: $43,302.										9
10	Wall Repair			00	4,350		10	218	218	218	10
11	Scrape & Painting Doors & Stairs			00	850		10	43	43	43	11
12	Painting			00	4,085		10	204	204	204	12
13	Sump Pump & Parts			00	1,824		10	91	91	91	13
14	Nurse Call System			00	1,013		10	51	51	51	14
15	Door Alarm & Nurse call system			00	1,774		10	89	89	89	15
16	Swing Door Automation			00	1,537		10	77	77	77	16
17	Rewire Control Circuit			00	2,406		10	120	120	120	17
18	Fan Wheels			00	2,188		10	109	109	109	18
19	Chiller			00	1,989		10	99	99	99	19
20	Air Conditioner			00	1,372		10	69	69	69	20
21	Heating System			00	3,422		10	171	171	171	21
22	Heating System			00	6,372		10	319	319	319	22
23	Air Conditioner			00	3,007		10	150	150	150	23
24	Tub Wall			00	2,667		10	133	133	133	24
25	Sliding Door			00	1,067		10	53	53	53	25
26	Sliding Door			00	1,862		10	93	93	93	26
27	Activator Motor			00	1,517		10	76	76	76	27
28	Capitalized Maint. & Repair.00: $10,299										28
29	Decorating			00	2,960		10	148	148	148	29
30	Plumbing			00	4,426		10	221	221	221	30
31	Repair concrete			00	2,913		10	146	146	146	31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 53,601	$ 0		$ 2,680	$ 2,680	$ 2,680	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,643,302	$ 139,637	$ 139,637	$		$ 1,065,557	37
38	Current Year Purchases	113,989	5,699	5,699			5,699	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,757,291	$ 145,336	$ 145,336	$		$ 1,071,256	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility - Maintenance	Chevy Pickup	1996	$ 20,106	$ 4,021	$ 4,021	$		$ 18,095	42
43										43
44										44
45										45
46	TOTALS			$ 20,106	$ 4,021	$ 4,021	$		$ 18,095	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 20,029,278	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 981,282	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 983,962	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 2,680	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 8,224,692	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

LIEBERMAN LONG TERM CARE FACILITY
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
06/30/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
LIEBERMAN	1,649,122	140,219	140,219		1,067,371
less reclass to limp per letter dated 7.28.2000	(5,820)	(582)	(582)		(1,814)
Item 2(b)					
TOTALS	1,643,302	139,637	139,637		1,065,557
LINE 29: CURRENT YEAR					
LIEBERMAN	113,989	5,699	5,699		5,699
less reclass to limp per letter dated 7.28.2000					
Item 2(b)					
TOTALS	113,989	5,699	5,699		5,699
LINE 30: FULLY DEPRECIATED					
LIEBERMAN					
less reclass to limp per letter dated 7.28.2000					
Item 2(b)					
TOTALS					
TOTALS (Should Tie to Totals on Page 13)					
LIEBERMAN	1,763,111	145,918	145,918		1,073,070
less reclass to limp per letter dated 7.28.2000	(5,820)	(582)	(582)		(1,814)
Item 2(b)					
TOTALS	1,757,291	145,336	145,336		1,071,256

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 25,600 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$ N/A	$ N/A	$ N/A	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 79,499	$		$ 79,499	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			30,750			30,750	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			105,382			105,382	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				61,764		61,764	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-2				0	37,902		37,902	13
14	TOTAL			$		$ 215,631	$ 99,666		$ 315,297	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1		
2	Complex Medical Equip	7,389
3	Oxygen	26,566
4		
5	Vaccine Expense	3,947
6		
7		
8		
9		
10		
		37,902

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 50,802	$	1
2	Cash-Patient Deposits	486,831		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,258,806		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,447,656		5
6	Prepaid Insurance	73,804		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	226,185		8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,544,084	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	809,873		13
14	Buildings, at Historical Cost	10,112,795		14
15	Leasehold Improvements, at Historical Cos	7,067,092		15
16	Equipment, at Historical Cost	1,789,727		16
17	Accumulated Depreciation (book methods)	(8,223,763)		17
18	Deferred Charges	224,279		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,780,003	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,324,087	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 28,880	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	571,368		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	779,639		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	4,156,887		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,536,774	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	13,948		39
40	Mortgage Payable			40
41	Bonds Payable	8,000,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,013,948	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,550,722	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,773,365	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,324,087	$	48

***(See instructions.)**

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY **#** 0026195 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 06/30/00

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
			DUE TO CJE	4,156,887	
				4,156,887	
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,757,474	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,757,474	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(984,109)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (984,109)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,773,365	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	LIEBERMAN LONG TERM CARE FA #	0026195	Report Period Beginning:	07/01/99	Ending:	**06/30/00**

Balance per General Ledger		3,723,444
Adjustments:		
Balance Sheet Finalized after cr submitted		34,030
		-
		-
Total adjustments		34,030
Balance - Beginning of Year		3,757,474
Equity(Deficit) from Page 17 Col 1		2,773,365
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		2,773,365

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,498,607	1
2	Discounts and Allowances for all Levels	(623,375)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,875,232	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	274,396	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 274,396	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	32,805	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	79,411	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	219,700	19
20	Radiology and X-Ray	2,729	20
21	Other Medical Services	38,502	21
22	Laundry	27,780	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 400,927	23
	D. Non-Operating Revenue		
24	Contributions	44,934	24
25	Interest and Other Investment Income***	177,049	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 221,983	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	212,646	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 212,646	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,985,184	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,923,591	31
32	Health Care	5,763,883	32
33	General Administration	3,200,979	33
	B. Capital Expense		
34	Ownership	1,593,258	34
	C. Ancillary Expense		
35	Special Cost Centers	355,822	35
36	Provider Participation Fee	131,760	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,969,293	40
41	**Income before Income Taxes (line 30 minus line 40)****	(984,109)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (984,109)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LIEBERMAN LONG TERM CARE # 0026195 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUPPLEMENTAL SCHEDULE OF REVENUES
06/30/00

	DESCRIPTION	AMOUNT
1		
2		
3	CATERING INC-O/S CJE	10,323
4		
5	MISC INCOME PRIMARY	21,618
6		
7	CATERING INCOME	44,154
8		
9	SUPPLIES CLEARING ACCT.	19,071
10		
11	FERIP/FERST INCOME	37,321
12		
13	TRANSFERS FROM CJE	50,666
14		
15	TRANSFERS FROM DEBT SERVICE	29,493
	TOTALS	212,646

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,713	1,923	$ 64,789	$ 33.69	1
2	Assistant Director of Nursing	1,884	2,335	66,733	28.58	2
3	Registered Nurses	68,100	69,033	1,628,744	23.59	3
4	Licensed Practical Nurses	15,161	17,833	326,297	18.30	4
5	Nurse Aides & Orderlies	265,455	274,292	2,592,065	9.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,037	12,009	143,534	11.95	8
9	Activity Director	1,715	1,922	39,173	20.38	9
10	Activity Assistants	15,033	16,743	196,226	11.72	10
11	Social Service Workers	10,489	9,875	203,417	20.60	11
12	Dietician	3,303	3,845	105,702	27.49	12
13	Food Service Supervisor	5,278	5,775	89,887	15.56	13
14	Head Cook	5,441	6,017	78,307	13.01	14
15	Cook Helpers/Assistants	34,022	38,903	346,932	8.92	15
16	Dishwashers					16
17	Maintenance Workers	15,251	19,905	276,110	13.87	17
18	Housekeepers	29,852	32,193	286,518	8.90	18
19	Laundry	12,617	13,871	131,817	9.50	19
20	Administrator	2,530	2,604	84,082	32.29	20
21	Assistant Administrator	3,080	3,280	84,962	25.90	21
22	Other Administrative	17,823	19,522	253,016	12.96	22
23	Office Manager					23
24	Clerical	47,269	48,402	529,306	10.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	567,053	600,282	$ 7,527,617 *	$ 12.54	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	1,925	$ 48,130	1-3	35
36	Medical Director	125	9,167	9-3	36
37	Medical Records Consultant	158	3,940	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	224	5,600	10-3	39
40	Physical Therapy Consultant	11	560	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	250	2,589	11-3	44
45	Social Service Consultant				45
46	Other(specify) Kashruth Supervisor	458	16,038	1-3	46
47	Medical Consultants	587	20,556	10-3	47
48	Rabbi Consultant	820	28,699	12-3	48
49	TOTAL (lines 35 - 48)	4,558	$ 135,279		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,002	$ 48,454	10-3	50
51	Licensed Practical Nurses	118	4,290	10-3	51
52	Nurse Aides	2,307	52,616	10-3	52
53	TOTAL (lines 50 - 52)	3,427	$ 105,360		53

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Wexler	Administrator		$ 84,082
Crosier, Glen	Assoc. Exec.Dir		55,608
Silverstein, Mary Ellen	Assoc. Exec.Dir		53,560
Silverstein, Daniel	Assoc. Exec.Dir		53,560
Weismehl, Ronald	Executive Director		90,288
Croix, Ann-Lisa	Assist. Admn.		37,524
Krasko, Sandy	Assist. Admn.		47,438
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 422,060

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
AM&G	Accounting Services	15,830
Alloc. CJE	Data Processing	175,000
See Schedule Attached	Other Prof. Services	143,067
Rosenthal and Schanfield	Legal Fees	1,390
Katten Muchin & Zavis	Legal Fees	508
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 335,795

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 161,600
Unemployment Compensation Insurance	
FICA Taxes	574,774
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Fringe Benefits & Welfare	910,107
FERIP/FERST INCOME	(37,321)
Alloction CJE	32,127
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,641,287

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	50,592
Health Care Worker Background Check	700
(Indicate # of checks performed 70)	
Organization Dues Agency	19,889
Subscription Expense	968
Yellow Page Advertising	277
Permits	221
Promotional Advertising	2,839
Alloc. CJE	3,299
Less: Public Relations Expense	( )
Non-allowable advertising	(2,839)
Yellow page advertising	(277)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 75,669

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,632
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,632

**See instructions.

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Deferred Maintenance		$ 132,633		$ 7,987	$ 9,945	$ 8,949	$ 8,702	$ 7,139	$ 6,877	$ 5,640	$ 5,211	$ 4,186
2													
3													
4													
5													
6													
7													
8													
9													
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14													
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16													
17													
18													
19													
20	TOTALS		$ 132,633		$ 7,987	$ 9,945	$ 8,949	$ 8,702	$ 7,139	$ 6,877	$ 5,640	$ 5,211	$ 4,186

Facility Name & ID Number LIEBERMAN LONG TERM CARE FACILITY # 0026195 Report Period Beginning: 07/01/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **19,889 JCAHO, LSNI, APIC**

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **124,885** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **131,760**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **YES** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **44,154**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Altschuler, Melvin & Glaser** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Preliminary Financial Statements**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw